

FILED JUL 29 1954

STANDARD CERTIFICATE OF DEATH

5421 State File No. 22607

No. 300
10.48

BIRTH NO. --- REG. DIST. NO. 108 PRIMARY REG. DIST. NO. 5420 Registrar's No. 12

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Dunklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Dunklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gibson		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gibson	
c. LENGTH OF STAY (In this place) Yrs		d. STREET ADDRESS (If rural, give location) 0350	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Mollie b. (Middle) Todd c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) July 5, 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH May 14, 1877		9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S					

13a. FATHER'S NAME Thomas Davidson		13b. MOTHER'S MAIDEN NAME Josie Northington		14. NAME OF HUSBAND OR WIFE J. J. Todd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Anna Russom Gibson ADDRESS Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis - Acute Failure -			INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 4 mos.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4222			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/1, 1945, to 7/5, 1954, that I last saw the deceased alive on 7/5, 1954, and that death occurred at 11:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wallace A. Belsey M.D.		23b. ADDRESS Campbell, Mo.		23c. DATE SIGNED 7/15/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Buried		24b. DATE July 7, 1954		24c. NAME OF CEMETERY OR CREMATORY North Cana	
				24d. LOCATION (City, town, or county) (State) Gibson Mo	

DATE REC'D BY LOCAL REG. 7-17-54		REGISTRAR'S SIGNATURE J. Anderson 89		25. FUNERAL DIRECTOR'S SIGNATURE W. H. Irby ADDRESS Rector Ark	
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RECEIVED DUNKLIN COUNTY HEALTH
DEPARTMENT 7-28-54
COUNTY FILE NUMBER 754-277

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

..... Student Embalmer No. _____
working under my personal supervision.

Signed
Student Embalmer

Signed Ran W. McBride

Licensed Embalmer No. 776

P. O. Address Rectors Ark.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.